DOUGLAS COUNTY HEALTH DEPARTMENT
INFLUENZA INFORMATION/CONSENT FORM
2013-2014 Season

CIRCLE

1. IS THIS THE VERY FIRST FLU SHOT YOU HAVE EVER HAD? YES NO

2 .DO YOU FEEL SICK TODAY OR HAVE A FEVER? YES NO

3. HAVE YOU EVER HAD ***SEVERE*** *REACTION* TO THE FLU SHOT? YES NO
   ***IF YES, PLEASE EXPLAIN: _____

4. HAVE YOU EVER HAD GULLAIN BARRE' SYNDROME WTHIN 6 WEEKS OF A PREVIOUS INFLUENZA IMMUNIZATION ? YES NO
   (This affects the central nervous system as an ascending/upwardly moving paralysis.)

5. DO YOU HAVE AN ALLERGIC REACTION TO EATING *LIGHTLY SCRAMBLED* EGGS? YES NO

6. HAVE YOU EVER HAD A REACTION TO LATEX? YES NO

7. DO YOU HAVE A BLOOD CLOTTING DISORDER AND/OR TAKE ANTICOAGULANT MEDICATION WHICH MAY RESULT IN INCREASED BRUISING? YES NO

I *have read or have had explained to me the information on this form about influenza and influenza vaccine. I have been provided w/ the Vaccine Information Statement for Inactivated Influenza Vaccine 2013-2014 and had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine, including side effects, and request that the vaccine be given to me.*

X
LAST NAME (Please Print *ABOVE*) **FIRST** **MI** **DOB/AGE**
X
ADDRESS (*ABOVE*)
X
SIGNATURE (*ABOVE*) **DATE**
(PLEASE CIRCLE) ***DCHD*** ***DOUGLAS COUNTY***
*** *UNITED HEALTH CARE INSURANCE* *YES* *NO*

VACCINE: FLUZONE (SANOFI PASTEUR) **Lot#:** **Exp:**

DOSE: 0. 5ml **ROUTE: Intramuscular**

SITE: (Please circle) **Right Deltoid** **Left Deltoid**

SCREENED BY: _____

ADMINISTERED BY: _____ DATE: _____